# Check Refund Form (REF-02)

Mail To: HP
Refunds
P.O. Box 241684
Montgomery, AL 36124-1684

Provider Name _____ NPI Number _____

Check Number _____ Check Date _____ Check Amount _____

| **Information needed on each claim being refunded** | **Claim 1** | **Claim 2** | **Claim 3** |
|---|---|---|---|
| 13-digit Claim Number (from EOP) | | | |
| Recipient's ID Number (from EOP) | | | |
| Recipient's name (Last, First) | | | |
| Date(s) of service on claims | | | |
| Date of Medicaid payment | | | |
| Date(s) of service being refunded | | | |
| Service being refunded | | | |
| Amount of refund | | | |
| Amount of insurance received, if applicable | | | |
| Insurance Co. name, address, and policy number, if applicable | | | |
| Reason for return (see codes listed below) | | | |

1. B ILL: An incorrect billing or keying error was made
2. DUP: A payment was made by Alabama Medicaid more than once for the same service(s)
3. INS: A payment was received by a third party source other than Medicare
4. MC ADJ: An over application of deductible or coinsurance by Medicare has occurred
5. PNO: A payment was made on a recipient who is not a client in your office
6. OTHER: (Please explain)

_____

_____

Signature _____ Date _____ Telephone _____

2-10-10